

MONTANA LEGISLATIVE HISTORY

Chapter 579 19 91

Bill H 930 S _____

Original bill & history ✓ c

H. Committee on Human Services & Aging

Hearing Date(s) Feb 22 ✓ c

_____ ✓ c

_____ ✓ c

_____ ✓ c

Date Out Feb 23 ✓ c

S. Committee on Public Health, Welfare & Safety

Hearing Date(s) Mar 20 ✓ c

Apr 01 ✓ c

_____ ✓ c

_____ ✓ c

Apr 03 ✓ c

Did this bill originate in an interim committee? Yes No

Committee _____

Report _____

HOUSE FINAL STATUS

HB 931

	RETURNED TO HOUSE WITH AMENDMENTS		
4/15	2ND READING AMENDMENTS CONCURRED	72	23
4/16	3RD READING AMENDMENTS CONCURRED	65	34
4/18	SIGNED BY SPEAKER		
4/19	SIGNED BY PRESIDENT		
4/19	TRANSMITTED TO GOVERNOR		
4/23	SIGNED BY GOVERNOR		
	CHAPTER NUMBER 578		

EFFECTIVE DATE: 7/01/91

HB 928 INTRODUCED BY TOOLE, ET AL.

ALLOW A CITIZEN TO BRING SUIT FOR ENVIRONMENTAL PROTECTION

2/18	INTRODUCED
2/18	REFERRED TO JUDICIARY
2/18	FIRST READING
2/22	HEARING
2/22	TABLED IN COMMITTEE

HB 929 INTRODUCED BY WHALEN, ET AL.

PROPERTY TAXATION OF 100 H.P. MOTOR BOATS

2/18	INTRODUCED
2/18	REFERRED TO TAXATION
2/18	FIRST READING
2/18	FISCAL NOTE REQUESTED
2/23	FISCAL NOTE RECEIVED
2/27	FISCAL NOTE PRINTED
3/20	HEARING
3/22	TABLED IN COMMITTEE

HB 930 INTRODUCED BY WHALEN, ET AL.

INCORPORATE INTO MONTANA LAW THE FEDERAL PROVISIONS
REGARDING PROTECTION AND ADVOCACY FOR THE
MENTALLY ILL

2/18	INTRODUCED		
2/18	REFERRED TO HUMAN SERVICES & AGING		
2/19	FIRST READING		
2/22	HEARING		
2/23	COMMITTEE REPORT—BILL PASSED		
2/23	PLACED ON CONSENT CALENDAR		
2/26	3RD READING PASSED	99	0

	TRANSMITTED TO SENATE		
2/26	FIRST READING		
2/26	REFERRED TO PUBLIC HEALTH, WELFARE & SAFETY		
3/20	HEARING		
4/02	COMMITTEE REPORT—BILL CONCURRED AS AMENDED		
4/04	2ND READING CONCURRED	49	0
4/05	3RD READING CONCURRED	49	1

	RETURNED TO HOUSE WITH AMENDMENTS		
4/10	2ND READING AMENDMENTS CONCURRED	93	1
4/11	3RD READING AMENDMENTS CONCURRED	98	1
4/18	SIGNED BY SPEAKER		
4/19	SIGNED BY PRESIDENT		
4/19	TRANSMITTED TO GOVERNOR		
4/23	SIGNED BY GOVERNOR		
	CHAPTER NUMBER 579		

EFFECTIVE DATE: 10/01/91

HB 931 INTRODUCED BY S. RICE, ET AL.

PARTIALLY FUND COURT BAILIFF EXPENSES
BY INCREASING DISTRICT COURT FEES

2/18	INTRODUCED
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HOUSE BILL 930

Introduced by Whalen, et al.

2/18	Introduced
2/18	Referred to Human Services & Aging
2/19	First Reading
2/22	Hearing
2/23	Committee Report--Bill Passed
2/23	Placed on Consent Calendar
2/26	3rd Reading Passed
	Transmitted to Senate
2/26	First Reading
2/26	Referred to Public Health, Welfare & Safety
3/20	Hearing
4/02	Committee Report--Bill Concurred as Amended
4/04	2nd Reading Concurred
4/05	3rd Reading Concurred
	Returned to House with Amendments
4/10	2nd Reading Amendments Concurred
4/11	3rd Reading Amendments Concurred
4/18	Signed by Speaker
4/19	Signed by President
4/19	Transmitted to Governor
4/23	Signed by Governor
	Chapter Number 579

1 ~~HOUSE~~ BILL NO. 730
 2 INTRODUCED BY *Whalen, Blylock, B. McCarthy*
 3 *Harmon, Beck, Blylock*
 4 A BILL FOR AN ACT ENTITLED: "AN ACT INCORPORATING INTO
 5 MONTANA LAW THE FEDERAL PROVISIONS REGARDING PROTECTION AND
 6 ADVOCACY FOR THE MENTALLY ILL; OUTLINING THE GOALS AND
 7 AUTHORITY OF AN ELIGIBLE PROTECTION AND ADVOCACY SYSTEM FOR
 8 THE MENTALLY ILL IN MONTANA; AND AMENDING SECTIONS
 9 53-21-141, 53-21-142, 53-21-144, 53-21-146, 53-21-147,
 10 53-21-162, 53-21-166, AND 53-21-181, MCA."

11
 12 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

13 NEW SECTION. **Section 1. Protection and advocacy system**
 14 -- designation and authority. (1) A protection and advocacy
 15 system for individuals with a significant mental illness or
 16 emotional impairment is designated by the governor and may
 17 be administered in the state under the provisions of 42
 18 U.S.C. 10801 through 10851. An eligible mental health
 19 protection and advocacy system under the provisions of 42
 20 U.S.C. 10801 through 10851 must have as its primary goals:

- 21 (a) the protection and advocacy of the rights of
 22 mentally ill individuals who are defined in 42 U.S.C. 10802
 23 as individuals with a significant mental illness or
 24 emotional impairment; and
 25 (b) the investigation of incidents of abuse and

1 neglect, as defined in 42 U.S.C. 10802, of mentally ill
 2 individuals.

3 (2) Pursuant to 42 U.S.C. 10801 through 10802, the
 4 protection and advocacy system may:

5 (a) investigate incidents of abuse and neglect of
 6 mentally ill individuals;

7 (b) pursue administrative, legal, and other appropriate
 8 remedies to ensure the protection of mentally ill
 9 individuals who are residents of the state and are receiving
 10 care or treatment in the state;

11 (c) have access to all mentally ill individuals and all
 12 facilities, wards, and living quarters as necessary to
 13 fulfill the goals described in subsection (1); and

14 (d) pursuant to 42 U.S.C. 10801 through 10851 and Title
 15 50, chapter 16, part 5, have access to records, including:

16 (i) reports prepared by the staff of a mental health
 17 care and treatment facility;

18 (ii) reports prepared by an agency investigating
 19 reports of abuse, neglect, and injury occurring at a
 20 facility and that describe the incidents and the steps taken
 21 to investigate the reports; and

22 (iii) discharge planning records.

23 (3) All information obtained under this section must be
 24 kept confidential pursuant to 42 U.S.C. 10806.

25 (4) The protection and advocacy system described in

1 this section is independent of any public or private agency
2 that provides treatment or services to the mentally ill.

3 **Section 2.** Section 53-21-141, MCA, is amended to read:

4 "53-21-141. Civil and legal rights of person committed.

5 (1) Unless specifically stated in an order by the court, a
6 person involuntarily committed to a facility for a period of
7 evaluation or treatment does not forfeit any legal right or
8 suffer any legal disability by reason of the provisions of
9 this part except insofar as it may be necessary to detain
10 the person for treatment, evaluation, or care. All
11 communication between an alleged mentally ill person and a
12 professional person is privileged under normal privileged
13 communication rules unless it is clearly explained to the
14 person in advance that the purpose of an interview is for
15 evaluation and not treatment.

16 (2) Whenever a person is committed to a mental health
17 facility for a period of 3 months or longer, the court
18 ordering the commitment may make an order stating
19 specifically any legal rights which are denied the
20 respondent and any legal disabilities which are imposed on
21 him. As part of its order, the court may appoint a person to
22 act as conservator of the respondent's property. Any
23 conservatorship created pursuant to this section terminates
24 upon the conclusion of the involuntary commitment if not
25 sooner terminated by the court. A conservatorship or

1 guardianship extending beyond the period of involuntary
2 commitment may not be created except according to the
3 procedures set forth under Montana law for the appointment
4 of conservators and guardians generally. In the case of a
5 person admitted to a program or facility for the purpose of
6 receiving mental health services, an individual employed by
7 or receiving remuneration from the program or facility may
8 not act as the person's guardian or representative unless
9 the program or facility can demonstrate that no other person
10 is available or willing to act as the person's guardian or
11 representative.

12 (3) A person who has been committed to a mental health
13 facility pursuant to this part is automatically restored
14 upon the termination of the commitment to all of his civil
15 and legal rights which may have been lost when he was
16 committed. This subsection does not affect, however, a
17 guardianship or conservatorship created independently of the
18 commitment proceedings according to the provisions of
19 Montana law relating to the appointment of conservators and
20 guardians generally. A person who leaves a mental health
21 facility following a period of evaluation and treatment
22 shall be given a written statement setting forth the
23 substance of this subsection.

24 (4) A person committed to a mental health facility
25 prior to July 1, 1975, enjoys all the rights and privileges

of a person committed after that date."

Section 3. Section 53-21-142, MCA, is amended to read:

"53-21-142. Rights of persons admitted to facility.

Patients admitted to a mental health facility, whether voluntarily or involuntarily, shall have the following rights:

(1) Patients have a right to privacy and dignity.

(2) Patients have a right to the least restrictive conditions necessary to achieve the purposes of commitment.

Patients must be accorded the right to appropriate treatment and related services in a setting and under conditions that:

(a) are the most supportive of the patient's personal liberty; and

(b) restrict the patient's liberty only to the extent necessary and consistent with the patient's treatment need, applicable requirements of law, and judicial orders.

(3) Patients shall have the same rights to visitation and reasonable access to ~~private~~ telephone communications, including the right to converse with others privately, as patients-at-any-public-hospitals except to the extent that the professional person responsible for formulation of a particular patient's treatment plan writes an order imposing special restrictions. The written order must be renewed after each periodic review of the treatment plan if any restrictions are to be continued. Patients shall have an

unrestricted right to visitation with attorneys, with spiritual counselors, and with private physicians and other professional persons.

(4) Patients shall have an unrestricted right to send sealed mail. Patients shall have an unrestricted right to receive sealed mail from their attorneys, private physicians and other professional persons, the mental disabilities board of visitors, courts, and government officials. Patients shall have a right to receive sealed mail from others except to the extent that a professional person responsible for formulation of a particular patient's treatment plan writes an order imposing special restrictions on receipt of sealed mail. The written order must be renewed after each periodic review of the treatment plan if any restrictions are to be continued.

(5) Patients have an unrestricted right to have access to letter-writing materials, including postage, and have a right to have staff members of the facility assist persons who are unable to write, prepare, and mail correspondence.

(6) Patients have a right to wear their own clothes and to keep and use their own personal possessions, including toilet articles, except insofar as such clothes or personal possessions may be determined by a professional person in charge of the patient's treatment plan to be dangerous or otherwise inappropriate to the treatment regimen. The

1 facility has an obligation to supply an adequate allowance
2 of clothing to any patients who do not have suitable
3 clothing of their own. Patients shall have the opportunity
4 to select from various types of neat, clean, and seasonable
5 clothing. Such clothing shall be considered the patient's
6 throughout his stay at the facility. The facility shall make
7 provision for the laundering of patient clothing.

8 (7) Patients have the right to keep and be allowed to
9 spend a reasonable sum of their own money.

10 (8) Patients have the right to religious worship.
11 Provisions for such worship shall be made available to all
12 patients on a nondiscriminatory basis. No individual shall
13 be required to engage in any religious activities.

14 (9) Patients have a right to regular physical exercise
15 several times a week. Moreover, it shall be the duty of the
16 facility to provide facilities and equipment for such
17 exercise. Patients have a right to be outdoors at regular
18 and frequent intervals in the absence of contrary medical
19 considerations.

20 (10) Patients have the right to be provided, with
21 adequate supervision, suitable opportunities for interaction
22 with members of the opposite sex except to the extent that a
23 professional person in charge of the patient's treatment
24 plan writes an order stating that such interaction is
25 inappropriate to the treatment regimen.

1 (11) Patients have a right to receive prompt and
2 adequate medical treatment for any physical ailments. In
3 providing medical care, the mental health facility shall
4 take advantage of whatever community-based facilities are
5 appropriate and available and shall coordinate the patient's
6 treatment for mental illness with his medical treatment.

7 (12) Patients have a right to a diet that will provide
8 at a minimum the recommended daily dietary allowances as
9 developed by the national academy of sciences. Provisions
10 shall be made for special therapeutic diets and for
11 substitutes at the request of the patient or the friend of
12 respondent in accordance with the religious requirements of
13 any patient's faith. Denial of a nutritionally adequate diet
14 shall not be used as punishment.

15 (13) Patients have a right to a humane psychological and
16 physical environment within the mental health facilities.
17 These facilities shall be designed to afford patients with
18 comfort and safety, promote dignity, and ensure privacy. The
19 facilities shall be designed to make a positive contribution
20 to the efficient attainment of the treatment goals set for
21 the patient. In order to assure the accomplishment of this
22 goal:

23 (a) regular housekeeping and maintenance procedures
24 which will ensure that the facility is maintained in a safe,
25 clean, and attractive condition shall be developed and

1 implemented;

2 (b) there must be special provision made for geriatric
3 and other nonambulatory patients to assure their safety and
4 comfort, including special fittings on toilets and
5 wheelchairs. Appropriate provision shall be made to permit
6 nonambulatory patients to communicate their needs to the
7 facility staff.

8 (c) pursuant to an established routine maintenance and
9 repair program, the physical plant of every facility shall
10 be kept in a continuous state of good repair and operation
11 in accordance with the needs of the health, comfort, safety,
12 and well-being of the patients;

13 (d) every facility must meet all fire and safety
14 standards established by the state and locality. In
15 addition, any hospital shall meet such provisions of the
16 life safety code of the national fire protection association
17 as are applicable to hospitals. Any hospital shall meet all
18 standards established by the state for general hospitals
19 insofar as they are relevant to psychiatric facilities.

20 (14) A patient at a facility has the right:

21 (a) to be informed of the rights described in this
22 section at the time of his admission and periodically
23 thereafter, in language and terms appropriate to the
24 patient's condition and ability to understand;

25 (b) to assert grievances with respect to infringement

1 of the rights described in this section, including the right
2 to have a grievance considered in a fair and timely manner
3 according to an impartial grievance procedure that must be
4 provided for by the facility; and

5 (c) to exercise the rights described in this section
6 without reprisal and may not be denied admission to the
7 facility as reprisal for the exercise of the rights
8 described in this section.

9 (15) In order to assist a person admitted to a program
10 or facility in the exercise or protection of the patient's
11 rights, the patient's attorney, advocate, or legal
12 representatives shall have reasonable access to:

13 (a) the patient;

14 (b) the program or facility areas where the patient has
15 received treatment or has resided or the areas to which he
16 has had access; and

17 (c) pursuant to the written authorization of the
18 patient, records and information pertaining to the patient's
19 diagnosis, treatment, and related services.

20 (16) A person admitted to a facility shall have access
21 to any available individual or service that provides
22 advocacy for the protection of the person's rights and that
23 assist the person in understanding, exercising and
24 protecting his rights as described in this section.

25 (17) This section may not:

1 (a) obligate a professional person to administer
2 treatment contrary to the professional's clinical judgment;

3 (b) prevent a facility from discharging a patient for
4 whom appropriate treatment, consistent with the clinical
5 judgment of a professional person responsible for the
6 patient's treatment, is or has become impossible to
7 administer because of the patient's refusal to consent to
8 the treatment;

9 (c) require a facility to admit a person who has, on
10 prior occasions, repeatedly withheld consent to appropriate
11 treatment; or

12 (d) obligate a facility to treat a person admitted to
13 the facility solely for diagnostic evaluation."

14 **Section 4.** Section 53-21-144, MCA, is amended to read:

15 "53-21-144. Rights concerning photographs. (1) A person
16 admitted to a mental health facility may be photographed
17 upon admission for identification and the administrative
18 purposes of the facility. Such photographs shall be
19 confidential and shall not be released by the facility
20 except pursuant to court order.

21 (2) No other nonmedical photographs shall be taken or
22 used without consent of the patient or, if applicable, the
23 patient's legal guardian ~~or--the--friend--of---respondent~~
24 ~~appointed-by-the-court."~~

25 **Section 5.** Section 53-21-146, MCA, is amended to read:

1 "53-21-146. Right to be free from physical restraint
2 and isolation. Patients have a right to be free from
3 physical restraint and isolation. Except for emergency
4 situations in which it is likely that patients could harm
5 themselves or others and in which less restrictive means of
6 restraint are not feasible, patients may be physically
7 restrained or placed in isolation only on a professional
8 person's written order which explains the rationale for such
9 action. The written order may be entered only after the
10 professional person has personally seen the patient
11 concerned and evaluated whatever episode or situation is
12 said to call for restraint or isolation. Emergency use of
13 restraints or isolation shall be for no more than 1 hour, by
14 which time a professional person shall have been consulted
15 and shall have entered an appropriate order in writing. Such
16 written order shall be effective for no more than 24 hours
17 and must be renewed if restraint and isolation are to be
18 continued. Whenever a patient is subject to restraint or
19 isolation, adequate care shall be taken to monitor his
20 physical and psychiatric condition and to provide for his
21 physical needs and comfort. Physical restraint may not be
22 used as punishment, for the convenience of the staff, or as
23 a substitute for a treatment program."

24 **Section 6.** Section 53-21-147, MCA, is amended to read:

25 "53-21-147. Right not to be subjected to experimental

1 research. (1) Patients shall have a right not to be
 2 subjected to experimental research without the express and
 3 informed consent of the patient, if the patient is able to
 4 give such consent, and of his guardian, if any, and the
 5 friend of respondent appointed by the court after
 6 opportunities for consultation with independent specialists
 7 and with legal counsel. If there is no friend of respondent
 8 or if the friend of respondent appointed by the court is no
 9 longer available, then a friend of respondent who is in no
 10 way connected with the facility, the department, or the
 11 research project shall be appointed prior to the involvement
 12 of the patient in any experimental research. At least 10
 13 days prior to the commencement of such experimental
 14 research, the facility shall send notice of intent to
 15 involve the patient in experimental research to the patient,
 16 his next of kin, if known, his legal guardian, if any, the
 17 attorney who most recently represented him, and the friend
 18 of respondent appointed by the court.

19 (2) Such proposed research shall first have been
 20 reviewed and approved by the mental disabilities board of
 21 visitors before such consent shall be sought. Prior to such
 22 approval, the board shall determine that such research
 23 complies with the principles of the statement on the use of
 24 human subjects for research of the American association on
 25 mental deficiency and with the principles for research

1 involving human subjects required by the United States
 2 department of health, education, and welfare for projects
 3 supported by that agency.

4 (3) A patient has the right to appropriate protection
 5 before participating in an experimental treatment, including
 6 the right to a reasonable explanation of the procedure to be
 7 followed, expected benefits, relative advantages, and the
 8 potential risks and discomforts of any experimental
 9 treatment. A patient has the right to revoke at any time
 10 consent to an experimental treatment."

11 **Section 7.** Section 53-21-162, MCA, is amended to read:

12 **"53-21-162. Establishment of patient treatment plan --**
 13 **patient's rights.** (1) Each patient admitted as an inpatient
 14 to a mental health facility shall have a comprehensive
 15 physical and mental examination and review of behavioral
 16 status within 48 hours after admission to the mental health
 17 facility.

18 (2) Each patient shall have an individualized treatment
 19 plan. This plan shall be developed by appropriate
 20 professional persons, including a psychiatrist, and shall be
 21 implemented no later than 10 days after the patient's
 22 admission. Each individualized treatment plan shall contain:

23 (a) a statement of the nature of the specific problems
 24 and specific needs of the patient;

25 (b) a statement of the least restrictive treatment

1 conditions necessary to achieve the purposes of commitment;

2 (c) a description of intermediate and long-range
3 treatment goals, with a projected timetable for their
4 attainment;

5 (d) a statement and rationale for the plan of treatment
6 for achieving these intermediate and long-range goals;

7 (e) a specification of staff responsibility and a
8 description of proposed staff involvement with the patient
9 in order to attain these treatment goals;

10 (f) criteria for release to less restrictive treatment
11 conditions and criteria for discharge; and

12 (g) a notation of any therapeutic tasks and labor to be
13 performed by the patient.

14 (3) As part of his treatment plan, each patient shall
15 have an individualized after-care plan. This plan shall be
16 developed by a professional person as soon as practicable
17 after the patient's admission to the facility.

18 (4) In the interests of continuity of care, whenever
19 possible one professional person (who need not have been
20 involved with the development of the treatment plan) shall
21 be responsible for supervising the implementation of the
22 treatment plan, integrating the various aspects of the
23 treatment program, and recording the patient's progress.
24 This professional person shall also be responsible for
25 ensuring that the patient is released, where appropriate,

1 into a less restrictive form of treatment.

2 (5) The treatment plan shall be continuously reviewed
3 by the professional person responsible for supervising the
4 implementation of the plan and shall be modified if
5 necessary. Moreover, at least every 90 days each patient
6 shall receive a mental examination from and his treatment
7 plan shall be reviewed by a professional person other than
8 the professional person responsible for supervising the
9 implementation of the plan.

10 (6) A patient has the right:

11 (a) to ongoing participation, in a manner appropriate
12 to the patient's capabilities, in the planning of mental
13 health services to be provided and in the revision of the
14 plan;

15 (b) to a reasonable explanation of the following, in
16 terms and language appropriate to the patient's condition
17 and ability to understand:

18 (i) the patient's general mental condition and, if
19 given a physical examination, the patient's physical
20 condition;

21 (ii) the objectives of treatment;

22 (iii) the nature and significant possible adverse
23 effects of recommended treatments;

24 (iv) the reasons why a particular treatment is
25 considered appropriate;

1 (v) the reasons why access to certain visitors may not
2 be appropriate; and

3 (vi) any appropriate and available alternative
4 treatments, services, or providers of mental health
5 services; and

6 (c) not to receive treatment established pursuant to
7 the treatment plan in the absence of the patient's informed,
8 voluntary, and written consent to the treatment, except
9 treatment:

10 (i) during an emergency situation if the treatment is
11 pursuant to or documented contemporaneously by the written
12 order of a responsible mental health professional; or

13 (ii) permitted under the applicable law in the case of a
14 person committed to a facility by a court."

15 **Section 8.** Section 53-21-166, MCA, is amended to read:

16 **"53-21-166. Records to be confidential -- exceptions.**

17 All information obtained and records prepared in the course
18 of providing any services under this part to individuals
19 under any provision of this part shall be confidential and
20 privileged matter and shall remain confidential and
21 privileged after the individual is discharged from the
22 facility. Except as provided in Title 50, chapter 16, part
23 5, information and records may be disclosed only:

24 (1) in communications between qualified professionals
25 in the provision of services or appropriate referrals;

1 (2) when the recipient of services designates persons
2 to whom information or records may be released, provided
3 that if a recipient of services is a ward and his guardian
4 or conservator designates in writing persons to whom records
5 or information may be disclosed, such designation shall be
6 valid in lieu of the designation by the recipient; except
7 that nothing in this section shall be construed to compel a
8 physician, psychologist, social worker, nurse, attorney, or
9 other professional person to reveal information which has
10 been given to him in confidence by members of a patient's
11 family;

12 (3) to the extent necessary to make claims on behalf of
13 a recipient of aid, insurance, or medical assistance to
14 which he may be entitled;

15 (4) for research if the department has promulgated
16 rules for the conduct of research; such rules shall include
17 but not be limited to the requirement that all researchers
18 must sign an oath of confidentiality;

19 (5) to the courts as necessary to the administration of
20 justice;

21 (6) to persons authorized by an order of court, after
22 notice and opportunity for hearing to the person to whom the
23 record or information pertains and the custodian of the
24 record or information pursuant to the rules of civil
25 procedure;

1 (7) to members of the mental disabilities board of
2 visitors or their agents when necessary to perform their
3 functions as set out in 53-21-104."

4 **Section 9.** Section 53-21-181, MCA, is amended to read:

5 "53-21-181. Discharge during or at end of initial
6 commitment period -- patient's right to referral. (1) At
7 any time within the 3-month period provided for in
8 53-21-127(2), the patient may be discharged on the written
9 order of the professional person in charge of him. In the
10 event the patient is not discharged within the 3-month
11 period and if the term is not extended as provided for in
12 53-21-128, he shall be discharged by the facility at the end
13 of 3 months without further order of the court. Notice of
14 the discharge shall be filed with the court and the county
15 attorney at least 5 days prior to the discharge.

16 (2) Upon being discharged, each patient has a right to
17 be referred, as appropriate, to other providers of mental
18 health services."

19 **NEW SECTION. Section 10.** Codification instruction.

20 [Section 1] is intended to be codified as an integral part
21 of Title 53, chapter 21, and the provisions of Title 53,
22 chapter 21, apply to [section 1].

-End-

MINUTES

**MONTANA HOUSE OF REPRESENTATIVES
52nd LEGISLATURE - REGULAR SESSION**

COMMITTEE ON HUMAN SERVICES & AGING

Call to Order: By Rep. Angela Russell, Chair, on February 22, 1991, at 3:00 p.m.

ROLL CALL

Members Present:

Angela Russell, Chair (D)
Tim Whalen, Vice-Chairman (D)
Arlene Becker (D)
William Boharski (R)
Jan Brown (D)
Brent Cromley (D)
Tim Dowell (D)
Patrick Galvin (D)
Royal Johnson (R)
Betty Lou Kasten (R)
Thomas Lee (R)
Charlotte Messmore (R)
Jim Rice (R)
Sheila Rice (D)
Wilbur Spring (R)
Carolyn Squires (D)
Jessica Stickney (D)
Bill Strizich (D)
Rolph Tunby (R)

Members Excused: Stella Jean Hansen

Staff Present: David Niss, Legislative Council
Jeanne Krumm, Committee Secretary

Please Note: These are summary minutes. Testimony and discussion are paraphrased and condensed.

HEARING ON HB 831

Presentation and Opening Statement by Sponsor:

REP. JAN BROWN, House District 46, Helena, stated that this bill was requested by the Department of Institutions (DOI). This bill merely allows DOI to adopt the standards governing the approval of chemical dependency treatment programs.

Proponents' Testimony:

Darryl Bruno, Department of Institutions, submitted written testimony. EXHIBIT 1

Mona Jameson, self, stated that Title 53, Chapter 24 actually

Closing by Sponsor:

REP. JOHNSON stated that it is more realistic to deal with these conflicts in medical issues by administrative rule than by statutes.

EXECUTIVE ACTION ON HB 881

Motion/Vote: REP. JOHNSON MOVED HB 881 DO PASS AND BE PLACED ON THE CONSENT CALENDAR. Motion carried unanimously.

HEARING ON HB 930

Presentation and Opening Statement by Sponsor:

REP. TIMOTHY WHALEN, House District 93, Billings, stated that this bill incorporates into Montana law the essential elements of the law that was adopted by Congress for establishing the protection and advocacy of mentally ill persons.

Proponents' Testimony:

Mary Gallagher, Staff Attorney, Protection & Advocacy for Mentally Ill Individuals/Board of Visitors, submitted written testimony. EXHIBIT 17

Kelly Moorse, Director, Board of Visitors, stated that since 1975, they have had a patients rights section in the Mental Commitment and Treatment Act. Approximately four years ago this committee incorporated similar legislation when the federal nursing home bill of rights was incorporated into our state law. HB 930 does much the same. Passage of this bill will make Montana law consistent with the federal legislation.

Chris Bakula, Executive Director, Montana Advocacy Program, Inc., submitted written testimony. EXHIBIT 18

John Shontz, Mental Health Association of Montana, stated that in the national headquarters for the Mental Health Association, there is a big bell that is made out of iron that was forged from shackles and chains that held people in mental health institutions all over this country. This bill removes the last vested use of visible shackles that does not infringe professionals choice in terms of delivery of care, but it does allow people who are receiving the care to participate in the management of their treatment programs.

Marty Onishuk, Montana Association of Mentally Ill, she reiterated previous testimony.

Paul Meyer, Western Region Community Mental Health Council, stood in support of HB 930.

Jim Smith, Montana Association of Rehabilitation Facilities,

stated this is a great bill.

Dan Anderson, Administrator, Mental Health Division, Department of Institutions, stood in support of HB 930.

Opponents' Testimony: None

Questions From Committee Members: None

Closing by Sponsor: REP. WHALEN closed on HB 930.

EXECUTIVE ACTION ON HB 930

Motion: REP. WHALEN MOVED HB 930 DO PASS AND BE PLACED ON THE CONSENT CALENDAR.

Discussion:

REP. KASTEN asked what is the cost for this. REP. WHALEN stated that there won't be any cost. The Board of Visitors is already going to these institutions.

Vote: Motion carried unanimously.

HEARING ON HB 862

Presentation and Opening Statement by Sponsor:

REP. DOROTHY BRADLEY, House District 79, Bozeman, stated that this is necessary when less restrictive services are unavailable or inadequate. Under the current law, the language that is stricken from the bill states that a professional person certifies a mental disorder and then that professional person gets confirmation in the second stage the community mental health person that appropriate services are not available. The problem is that we have 6,000 professional persons that can do that. In this whole process there is no consultation that takes place with Montana State Hospital individuals. It is not a good system. The screening that we would like to take place should be clinically appropriate and there should be more knowledge funneled into the screening process from individuals who are very familiar with the role of the hospital and with exactly what is available to help community based services.

Proponents' Testimony:

Dan Anderson, Administrator, Mental Health Division, Department of Institutions, submitted written testimony. EXHIBIT 19

John Lynn, Director, Community Support Services for Western Montana Region Community Health Center, stated that over the last ten years he has seen community health centers develop programs increasing the capability of serving individuals with a serious mental illness in a community. There is clearly a lack of

OFFICE OF THE GOVERNOR
MENTAL DISABILITIES BOARD OF VISITORS
LEGAL SERVICES PROGRAM

EXHIBIT 17
DATE 2-22-91
HB 930



STAN STEPHENS, GOVERNOR

P.O. BOX 177

STATE OF MONTANA

(406) 693-7035

WARM SPRINGS, MONTANA 59756

TO: MT HOUSE HUMAN SERVICES COMMITTEE
FROM: MARY GALLAGHER-STAFF ATTORNEY *mg*
PROTECTION & ADVOCACY FOR MENTALLY ILL INDIVIDUALS/BOARD OF VISITORS
DATE: FEBRUARY 22, 1991
RE: HEARING ON HOUSE BILL 930

MADAME CHAIR AND MEMBERS OF THE COMMITTEE:

I am here today in support of House Bill 930 at the invitation of Representative Whalen. In 1986 the United States Congress established the Protection and Advocacy Act for Mentally Ill Individuals Act (PAMII) because of the problems it saw regarding the treatment and rights of persons with mental illness-particularly in institutions and other mental health facilities throughout the country.

Currently, the Montana PAMII program has the authority under the federal act to do everything listed in the New Section of this bill to address those treatment needs. However, passage of this bill would help to inform facilities that they are subject to cooperation with the program's federal mandate. It would provide notice in Montana law to facilities on what is required of them and provide guidance on confidentiality issues when an advocate visits their facility. To date, most facilities have been cooperative with these provisions but many had little, if any, knowledge of the existence of the federal mandates until they were contacted by the PAMII program. This bill would assist with notice to facilities and enable the program to meet its' mandate.

Secondly, this bill seeks to incorporate provisions from the federal Restatement of The Bill of Rights For Mental Patients which is also part of the PAMII Act. The Restatement spells out the federal guidelines of basic rights for what any patient at a mental health facility should be able to expect on how they should be treated and what they should expect in terms of limitations on rights and liberties. Most of these provisions already exist in our mental health code. This bill adds those basic provisions from the federal Restatement which are not are not currently in the code or which are not as specifically stated in the code.

The Restatement addresses very basic, but important, rights for persons with a serious mental illness who are in facilities-people who have not always able to speak up for themselves, and who, until recently, have had very little voice within the system that provides them with treatment. I urge the committee to pass this bill to affirm these basic rights and to ensure that the advocacy system can address the federal mandate without hindrance.

Thank you.

**WHAT DOES HB 930 ADD TO, OR CLARIFY, IN MONTANA'S
MENTAL HEALTH CODE?**

SECTION 1. The New Section clarifies what the PAMII system is designed to do, which is to investigate incidents of abuse and neglect of mentally ill individuals and seek remedies to assure their rights are respected within the mental health system. It states generally what the PAMII system shall have access to within mental health facilities. (Section 1; pg 1&2)

SECTION 2. This section address the circumstances wherein a provider of services may be called upon to be a guardian of one of its' clients. It is essentially a cautionary measure for a situation which could potentially be an exploitive situation, monetarily or otherwise. (see Sec.2; 53-21-141(2).)

SECTION 3. This section addresses the right to appropriate treatment under conditions which limit the restrictions placed on a person to only restrictions which are necessary and consistent with the individual's treatment needs and any judicial order. It adds the federal language on private conversations while a person is a patient. (Sec.3; pg 5; 53-21-142(2) and (3).);

Section 3 also provides for notification of a person in a mental health facility that a grievance procedure is available to address grievances about the facility. It requires the person be informed that he/she may exercise this procedure without retaliation and have access to an available advocate to address those concerns. (Sec.3; 53-21-142(14), (15), (16).)

A final sub-section of Sec.3 addresses the notion that the Restatement of Rights does not negate the professional persons' decisions regarding evaluation, treatment and discharge providing that professional judgment is utilized. (Sec.3; 53-21-142(17)).

SECTION 4. This section addresses a patient's consent to the taking of his or her photograph. (Sec.4, 53-21-144);

SECTION 5. This section addresses the notion that physical restraints may not be used for punishment, for convenience of staff or as a treatment substitute (Sec.5, 53-21-146);

SECTION 6. This section is further clarification on the use of experimental treatments (Sec.6, 53-21-147);

SECTION 7. This section addresses a patient's right to participate in their treatment planning in an informed way with reasonable explanations about the course of treatment and with their understanding and approval within the perimeters of applicable law; (Sec.7, 53-21-162)

SECTION 8. This section addresses the necessity to keep records confidential after discharge of the patient; (Sec.8, 53-21-166)

SECTION 9. This section addresses the rights of patients to receive appropriate discharge referrals when they leave a mental health facility. (Sec.9, 53-21-181)

17
2-22-91
930

TO: MT HOUSE HUMAN SERVICES COMMITTEE
FROM: MARY GALLAGHER
STAFF ATTORNEY
PROTECTION & ADVOCACY FOR MENTALLY ILL INDIVIDUALS/BOARD OF VISITORS
DATE: FEBRUARY 22, 1991

RE: HEARING ON HOUSE BILL 930 specifically on SECTION 7 -
regarding Informed Consent requirement for
treatment plans

Yesterday the Department expressed some concern about Section 7, 53-21-162(6)(c): regarding a patients right not to receive treatment established pursuant to the treatment plan in the absence of the patients informed consent to treatment. Two exceptions are listed: one for emergencies and the other for the applicable law for persons committed to a facility by the court. The concern expressed was for patients who refused to give informed consent to a treatment plan and for patients who were not able to give informed consent because of their mental(or physical) status.

These issues are addressed in several places in current Montana law. The first concern can be addressed by referring to the current code section 53-21-136 on provisions a facility may follow if a person committed to a facility fails to comply with a treatment plan. That section states:

COMPLIANCE WITH TREATMENT PLAN. If the respondent fails to comply or clearly refuses to comply with all or part of the treatment plan, the professional person appointed under 53-21-122 shall make all reasonable efforts to solicit the respondent's compliance. Such efforts must be documented and reported to the court with a recommendation to the court as to whether the respondent should:

- (1) have his case dismissed; or
 - (2) be given a supplemental hearing.
- Section 53-21-136, Mont.Code Ann.

The second concern can be addressed by referring to the Montana guardianship statutes in Title 72, MCA on how to deal with patients who are not able to give informed consent. Nothing in this bill would preclude a mental health facility from establishing policies to deal with those patients who are not able to give informed consent or who refuse treatment. Most facilities already have those policies in place. In fact, **HB 930 represents the generally accepted professional standards currently practiced in this state and elsewhere.** Therefore, any attempt to amend the bill on these issues is unnecessary and warranted.

EXHIBIT 18
DATE 2-22-91
HB 930 & 862

MONTANA ADVOCACY PROGRAM, Inc.

1410 Eighth Avenue
Helena, Montana 59601

(406)444-3889
1-800-245-4743

February 22, 1991

Representative Russell, Chair
Human Services and Aging Committee
Capitol Station
Helena, Montana 59620

RE: H.B. 862
H.B. 930

Dear Angela:

I have missed seeing you since your other commitments necessitated you vacating your seat on the State Planning Council! As you know the mission of the Montana Advocacy Program (MAP) is to protect and advocate for the rights of Montanans with disabilities while enhancing dignity and self-respect. I am submitting this written testimony today in support of two House Bills your committee will be hearing this afternoon.

The first, H.B. 862, revises the requirements for screening voluntary admissions to the Montana State Hospital. The meat of the revision is that "Before admission may be approved, the admitting professional making the referral shall consult with the designated admitting professional at the state hospital," and agreement is reached that services cannot be provided in the community and the admission is appropriate. While MAP will always advocate for community-based services over any institutional placement, we believe this revision is an improvement over the existing and builds in an additional safeguard for the individual. As such, we endorse this revision.

The second, H.B. 930, is "An Act incorporating the federal provisions regarding protection and advocacy for the mentally ill described in 42 U.S.C. 10801 et. seq. into Montana law...and amending" certain sections of existing 53-21-141. Passage of this bill will make Montana law consistent with the federal legislation referenced. MAP strongly endorses H.B. 930.

EXHIBIT 18
DATE 2-22-91
HB 930

Thank you for taking these comments into consideration. Please do not hesitate to contact me if I can provide you with additional information.

Sincerely,



Kristin Bakula
Executive Director

kb
c: File

7 .
2007
1007

HOUSE STANDING COMMITTEE REPORT

February 23, 1991

Page 1 of 1

Mr. Speaker: We, the committee on Human Services and Aging
report that House Bill 930 (first reading copy -- white) do
pass and be placed on consent calendar .

Signed: _____
Angela Russell, Chairman

HOUSE OF REPRESENTATIVES

VISITOR'S REGISTER

Human Services & Aging COMMITTEEBILL NO. HB 930DATE 2-22-91 SPONSOR(S) Rep. Tim Whalen

PLEASE PRINT

PLEASE PRINT

PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	BILL	OPPOSE	SUPPORT
Mary Gallagher	Board & Visitors/PAMI	930		X
John Lynn	Mental Health	930		X
Marty Onishuk	Mon AMI	1		X
Ken Moore	Board of Visitors	930		X
Dan Anderson	MT Dept Institutions	930		X
PAUL MEYER	Western Region Community MENTAL HEALTH CENTER	930		X
John Shute	Mental Health Assn. of MA	930		X

PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORMS
ARE AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.

MINUTES

MONTANA SENATE 52nd LEGISLATURE - REGULAR SESSION

COMMITTEE ON PUBLIC HEALTH, WELFARE & SAFETY

Call to Order: By Chairman Dorothy Eck, on March 20, 1991, at
3:15 p.m.

ROLL CALL

Members Present:

Dorothy Eck, Chairman (D)
Eve Franklin, Vice Chairman (D)
James Burnett (R)
Thomas Hager (R)
Judy Jacobson (D)
Bob Pipinich (D)
David Rye (R)
Thomas Towe (D)

Members Excused: None

Staff Present: Tom Gomez (Legislative Council)
Christine Mangiantini (Committee Secretary)

Please Note: These are summary minutes. Testimony and
discussion are paraphrased and condensed.

HEARING ON HOUSE BILL 761

Presentation and Opening Statement by Sponsor:

Representative Ray Peck opened by saying this measure combines several bills but authorizes the county attorney to order tests for sexually transmitted diseases following the entry of judgement against the sexual offender. Secondly, the bill requires the county attorney to arrange for counseling of the victim and the convicted person if the sexually transmitted disease test is positive. Third, the bill exempts the protection provided for on page 2, lines 5 and 6 relative to AIDS testing. The bill also provides for the release of the results by the county attorney and also meets the requirement of federal law relating to a possible penalty. He reviewed the amendments implemented by the House committee.

SENATE PUBLIC HEALTH, WELFARE & SAFETY COMMITTEE

March 20, 1991

Page 12 of 18

Senator Eck said there was another bill that would increase the number of eligible persons.

Mr. Hanschen said the Governor's budget contained an expansion by offering an additional 50 slots. Representative Boharski asked the Appropriations subcommittee to allow up to 25 individuals now in nursing homes to move into community services.

Senator Eck asked if the eligibility was based upon state or federal budgetary constraints.

Mr. Hanschen said it is both. Montana is reaching its federal limit. It is predicated on the number of empty nursing home beds. We have a high occupancy rate of nursing homes beds in Montana.

Closing by Sponsor:

Representative Whalen thanked the committee for a good hearing and urged passage.

EXECUTIVE ACTION ON HOUSE JOINT RESOLUTION 21

Motion:

Senator Hager moved concurrence.

Discussion:

None.

Recommendation and Vote:

There being 8 ayes and 0 nays the motion carried.

HEARING ON HOUSE BILL 930

Presentation and Opening Statement by Sponsor:

Representative Tim Whalen said this bill incorporates federal law provisions relating to the U.S. Congressional Act passed in 1986 for mentally ill advocacy. This would bring the Montana law parallel with the federal law, allowing more ease in providing the mandates for the advocacy of the mentally ill. He asked the chairman to recognize the witnesses.

Proponents' Testimony:

The first witness was Mary Gallagher, staff attorney for the Board of Visitors. See Exhibit #9 for a copy of her testimony which includes written testimony from Kelly Moorse.

SENATE PUBLIC HEALTH, WELFARE & SAFETY COMMITTEE

March 20, 1991

Page 13 of 18

The second witness was John McCrea, representing the Montana Advocacy Program. See Exhibit #10 for a copy of his testimony which included testimony from Krista Bakula, executive director of the Montana Advocacy Program.

The third witness was Dan Anderson, administrator of the Mental Health Division, Department of Institutions. He said they were provided with a draft of the bill before it was introduced. They went over it very thoroughly and worked with the Board of Visitors. This bill is supported by the Department of Institutions and the State Hospital. It is unfortunate that we need a section of law dealing with the rights of the mentally ill. One would assume they have the same rights as everyone else. The rights of the mentally ill have not been granted as they should have been. Service providers, today, are concerned about this. The Department of Institutions is joining with the advocates in support of this bill.

The fourth witness was Jim Smith, representing the Montana Association for Rehabilitation. The whole history of the nation is bound up in the rights of people who did not have them. Two hundred years ago you could not vote unless you owned property. Eighty years ago you could not vote unless you were a male. People with mental illnesses have rights and if this bill passes they will have additional rights. In so doing, the legislature and the society has to be sensitive to everyone's rights. We must balance the rights of those with mental illnesses against those hired to help them. This bill strikes a proper balance. The needs of the patients come first.

The fifth witness was Kathy McGowan, representing the Montana Council of Mental Health Centers. She said they are a provider and support the bill. She said the Montana Alliance for the Mentally Ill also supports the bill.

Opponents' Testimony:

The first witness was Archie McPhail, supervisor of the Intensive Treatment Unit at Montana State Hospital. See Exhibit #11 for a copy of his testimony. He said he was here on his own time and expense and his remarks were not reflective of the Department.

The second witness was Ginny Hill, a psychologist at Montana State Hospital. She was representing herself. She said she reviewed the bill and said a major concern was that the bill was developed without the input of staff at the State Hospital. One issue would adversely affect patient care, on page 17, section 7 (6c). She read this section. She said peers and staff would be at an increased risk of physical harm, illnesses will be harder to treat and untreated patients may be discharged to the community. She said once dangerous behaviors have occurred that involve mental illness the state has a moral obligation to prevent future episodes of violence.

Questions From Committee Members:

Senator Burnett asked Representative Whalen about the fiscal impact of the bill.

Representative Whalen said it would not cost any additional monies because the Board of Visitors is already established.

Senator Pipinich asked Jim Smith to respond to Mr. McPhail's testimony regarding section C.

Mr. Smith said the concern was genuine but felt it had been addressed. The patient had the right not to receive treatment unless it is during an emergency situation. The rights of the patient are forfeited through the order of the court or the emergency at hand.

The chairman recognized Mary Gallagher who said it was unfortunate that the hospital employees were not at the meeting the Board of Visitors had with the superintendent of the hospital. As the law stands, people must give informed consent. A guardian should be appointed to make the medical decisions. Most hospitals have that procedure in place. However, there is some confusion at the State Hospital about this responsibility.

Senator Pipinich asked Archie McPhail to respond.

Mr. McPhail said he had asked if any compromise had been reached on that section of the bill and received a variety of answers.

Senator Franklin asked Mr. McPhail about the guardianship proceedings.

Mr. McPhail said the only guardianship that occurs regularly pertains to money. Very seldom is a guardian appointed to determine treatment. Many patients refuse consent to treatment. He said one patient had been schizophrenic for 12 years. She was not treated for half of that time. With medication she was responding within a week and after that was sorry she had not consented to the medication earlier. He said they did not have much recourse if a patient would not submit to treatment. In this case we had a court order. Presently, there is a committee comprised of health care workers who are independent of the unit the patient is on. They decide about consent.

Senator Burnett asked if section C were stricken from the bill what the impact would be.

Mary Gallagher said these are the bottom line positions that all hospitals use regarding treatment. It would delete an area that needs clarification. Leaving this section in the bill may help to define this area.

SENATE PUBLIC HEALTH, WELFARE & SAFETY COMMITTEE

March 20, 1991

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Senator Franklin asked if it was reasonable to expect someone overtly psychotic to give written consent.

Mary Gallagher said when someone is in that state it is a situation where the treating physician may decide the person is not capable of giving consent. That is why the temporary guardianship provisions are in the mental health code.

Senator Jacobson said someone mentioned that most other facilities already do informed consent, is it not true that most involuntary commitments are made to the state hospital.

Mary Gallagher said the majority are made to the state hospital. Others are committed to psychiatric wards throughout the state. Other facilities have already established policies about informed consent. The state hospital has been more lax about defining that policy. We suggested that the community take some responsibility for guardianship proceedings as well.

Senator Franklin commented about the issue regarding written consent and the Board of Visitors process.

Mary Gallagher said the Board of Visitors is not appointed as guardian but has the legal services program available.

Senator Franklin said if someone is unable to give written consent and the psychiatrist feels that they are in need of treatment, they need to establish a guardian.

Mary Gallagher said persons with a mental illness that are committed under the statute may have the mental capacity to make a decision regarding treatment.

Senator Franklin said her contention was that the very patient's that need treatment, that are not deemed incompetent, do not receive it and the clinicians are caught in the bind.

Mary Gallagher said that was not correct. If a physician said the person could not make the treatment decision, that information is what is needed in a guardianship hearing to find incapacity. A guardian would be appointed.

Senator Pipinich asked Mr. McPhail to respond.

Mr. McPhail said it would be difficult to take them back to court to have a guardianship approved.

Senator Pipinich asked about his input on section C.

Mr. McPhail said he was in the meeting for five or ten minutes and was then replaced by the superintendent.

SENATE PUBLIC HEALTH, WELFARE & SAFETY COMMITTEE

March 20, 1991

Page 16 of 18

Senator Towe said one issue is commitment. Some psychiatrist's have had difficulty with the tight commitment procedures. There are times when people need to take their medicine on a regular basis or they become uncontrollable. A guardianship proceeding was developed which would allow for temporary holding of an individual and use of force to administer medication. This could not be done in Warm Springs. The question is whether or not the patient can refuse treatment. This has been a major debate. A decision was made that would require every patient to have a treatment plan.

Representative Whalen said we are talking about people capable of making these decisions. If they are not capable a guardianship can be established. If it is not an emergency situation, the person is incompetent, there is no reason why the guardianship proceedings should not be undertaken. If they are not incompetent but are mentally ill, that person should be making informed consent about his/her treatment plan. He said if section C were stricken it would create a huge problem. It speaks to the manner in which treatment is carried forward. You cannot read this bill in isolation. This provision is in federal law.

Mary Gallagher said section C was put in the bill because treatment plans were established but never discussed with the patient. The provisions allow a contract between the professionals and the patient. If someone does not agree to a treatment plan, the code addresses non-compliance. There must be a treatment plan in accordance with state law. However, if there is no participation, the professional must seek compliance. If that is not possible there is a statute dealing with that problem. The federal restatement of the Bill of Rights is not a substantive provision.

Senator Towe asked about provisions from other states.

Mary Gallagher said they use their guardianship provisions. If they are not incompetent and refuse treatment they have a hospital policy or go through a state statute.

Mr. McPhail commented that without compromise or without procedure we would be in court resolving the differences. The point is that we have not worked out a policy. We have an obligation to our patients. The least amount of medication is what is used. Over medication rarely occurs.

Senator Franklin asked Dan Anderson about current policies on instituting guardianship.

Mr. Anderson said he was not the right person to answer that question. He said we have a limited guardianship statute on the books. We do not have to prove the person is totally unable to take care of themselves. We can set up a procedure with the help of the Board of Visitors and the state hospital.

SENATE PUBLIC HEALTH, WELFARE & SAFETY COMMITTEE

March 20, 1991

Page 17 of 18

Senator Franklin said what concerns her is the set-up for the patients. We end up not treating them. They cannot consent to treatment because of their illness, we do not have a guardianship policy in place and as a result they get warehoused.

Mr. Anderson said not every patient refuses treatment. Section C caused him concern. This is a basic right all of us have. We have the right to understand the treatment and make a decision whether to accept it. It is difficult to say we are not going to offer that right to people because they are mentally ill.

Senator Franklin said she was hopeful there were enough other protection besides (c), including the Board of Visitors and community involvement. This issue of emergency situations says if someone is overtly aggressive they are medicated. The rest of the time they do not get treatment. That is not clinical treatment.

Chairman Eck asked Ginny Hill about section (c), adding language, and wanted to know what exceptions would be appropriate.

Ms. Hill said when a patient is received on a 90-day commitment, most Montana judges add a clause that states the patient may receive treatment by injection if necessary in order to treat the patient. She said she would like that clause included. We have to treat the dangerous patients. We make all efforts to get informed consent. Our experience with judges is that they believe it is within the patients right to refuse treatment. Ms. Hill continued by saying the voluntary commitments are not the problem. The involuntarily committed patient we cannot treat without their consent.

Chairman Eck said right now they are getting commitments and it might be appropriate to add language that allows treatment when it is in compliance with the commitment order.

Ms. Hill said a reference such as that would be helpful.

Chairman Eck said this bill was on the consent calendar in the House of Representatives.

Closing by Sponsor:

Representative Whalen closed by saying there were no problems with this bill. He said the misunderstandings were unfortunate. It results from the interpretation of the guardianship laws. This bill speaks to areas when treatment is required to address an emergency that no informed consent is required. A treatment plan for someone incompetent is denoted in the guardianship statutes. This bill applies to any facility that is dealing with mentally ill persons. If the person is not incompetent they should be allowed to refuse treatment. The intent of the bill is to give mentally ill persons rights.

OFFICE OF THE GOVERNOR
MENTAL DISABILITIES BOARD OF VISITORS

STAN STEPHENS, GOVERNOR

SENATE HEALTH & WELFARE

EXHIBIT NO. 9

DATE 3/20

H BILL NO. 930

CAPITOL STATION



STATE OF MONTANA

(406) 444-3955
OR TOLL FREE 1-(800)-332-2272

HELENA, MONTANA 59620

25 March 1991

Senator Dorothy Eck, Chair
Senate Public Health
State Capitol
Helena, MT 59620

Chairman Eck and Members of the Committee,

For the record, my name is Kelly Moorse and I serve as the director of the Mental Disabilities Board of Visitors. The members of the Board of Visitors support House Bill 930.

As an advocacy agency, we feel this bill and the Mental Health Consumer Bill (SB 326) are two of the most important pieces of mental health legislation this session, in that they directly affect the people who live a mental illness.

House Bill 930 incorporates the federal mental health rights into the Montana Mental Health Commitment Act. We feel this addition strengthens the existing law as proposed by Senator Towe in 1975. These efforts also correspond to the action of the 1987 Legislature when the federal nursing home rights were incorporated into Montana law.

We urge your support of House Bill 930. Thank you for your consideration of this legislation.

Sincerely,

A handwritten signature in cursive script that reads "Kelly Moorse".

Kelly Moorse
Executive Director

MONTANA ADVOCACY PROGRAM, Inc.

1410 Eighth Avenue
Helena, Montana 59601

(406)444-3889
1-800-245-4743

March 20, 1991

Dorothy Eck, Chair
Public Health, Welfare, and Safety Committee
Capitol Station
Helena, Montana 59620

Re: H.B. 930

Dear Ms. Eck:

I am writing to you today in support of H.B. 930 which will be heard by your committee this afternoon .

H.B. 930, is "An Act incorporating the federal provisions regarding protection and advocacy for the mentally ill described in 42 U.S.C. 10801 et. seq. into Montana law...and amending" certain sections of existing 53-21-141. Passage of this bill will make Montana law consistent with the federal legislation referenced.

As the executive director of the system designated to administer the federal mandate authorized by the legislation referenced above, I strongly endorse passage of H.B. 930. I encourage you, or any of the committee members, to contact me or my staff if you have any questions or need additional information regarding this bill.

Sincerely,



Kristin Bakula
Executive Director

kb
c: File

H B 930 Section 7-6C
Informed Consent

SENATE COMMITTEE ON WELFARE

EXHIBIT NO. 11

DATE 3/20/91

H BILL NO. 930

There is a tremendous difference between you and me going to a surgeon and having the ability to make an informed decision, compared to that of a mentally ill or mentally deranged person who lacks the ability, the knowledge, and insight to understand that they are not living in reality.

This one little paragraph will affect adversely, patients who are committed for treatment, their family who has usually risked much to have them treated, and the community that has sent them through the due process to be treated.

The vast majority of the seriously mentally ill do not realize they are suffering from a mental illness. Therefore, they live in a world which is a product of their imagination and illusions for which they need treatment.

Informed consent implies that involuntarily committed patients are competent and have knowledge of their illness to refuse treatment--until proven otherwise.

However the court has committed these patients, usually because they do not have knowledge of their illness and by law are a danger to themselves and/or others. They already have had due process.

Now if informed consent passes, these same recently involuntarily committed patients will have to be brought back into court, possibly for each treatment procedure, or for a guardian, or to authorize medications, or for all of the above.

This little paragraph, if passed could do the following:

1. It will leave patients, who refuse treatment, warehoused on a treatment ward, not participating, until their commitment is up or their dangerousness disappears so they can return to the community.
2. If the patient is incompetent, it will leave him warehoused until a court of law can prove otherwise.
3. It will place patients in significant risk when due process protections are extended at the expense of treatment.
4. Some patients will experience extensive delays in treatment while a court order to treat them is sought.
5. With other patients a course of least resistance will be taken -
- this now will be legally correct -- However it will be a clinically unfortunate discharge from the Montana State Hospital.

This legal approach places a high value on patient's wishes and assumes that patients statements are accurate and reflect the true intent of the patient.

Usually, the desire of the patient not to be treated comes from a psychotic mind, that has no sense of wholeness, no integration, who can not act independently, who does not demonstrate a capacity for self-governance and who does not have the knowledge to realize that his own beliefs are

Ex. 11
3/20/91
HB 930

Page 2

Informed consent implies that the world of the ego-syntonic grandiose psychotic is preferable to normality for the non compliant patient.

Psychotic reasoning and anger underlie most treatment refusals. By one author it is called, "Rotting With Their Rights On."

Compromise

1. Informed consent should be applied only to voluntary patients with the involuntary patients who already have had due process, having the right to treatment.
2. If this compromise is unacceptable we request a two year postponement until a compromise can be worked out.

Testimony by Archie McPhail

Did not speak -
Record test.

WITNESS STATEMENT

To be completed by a person testifying or a person who wants their testimony entered into the record.

Dated this 20 day of March, 1991.

Name: Marty Onishuk

Address: 5855 Pinewood Ln
Missoula, MT 59803

Telephone Number: 251-2754

Representing whom?

HonAMI - MT. Alliance for the Mentally Ill

Appearing on which proposal?

HB 930

Do you: Support? X Amend? Oppose?

Comments:

Necessary changes to comply with
fed. law + secure rights of mentally
ill.

WITNESS STATEMENT

To be completed by a person testifying or a person who wants their testimony entered into the record.

Dated this 20th day of March, 1991.

Name: Gill Ginny Hill

Address: Brainerd St

Warm Springs, MT 59756

Telephone Number: 406-693-7000

Representing whom?

Self

Appearing on which proposal?

House Bill 930

Do you: Support? Amend? Oppose? Section 7#6 c

Comments:

Dangerous seriously mentally ill pts should be treated.

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY

DATE WED. 7/20/91

COMMITTEE ON PUBLIC HEALTH

761, 881, 917, 930, HJ 21

VISITORS' REGISTER

NAME	REPRESENTING	BILL #	Check One	
			Support	Oppose
ITA Masters, R.N.	Columbus	917	✓	
Meryl Reichert, M.D.	Columbus Hospital, Great Falls	917	✓	
JUDITH Gedrose	Department of Health + Community Science	917	✓	
DR. DAWSON	EMS, Dept Health	917	✓	
DR. DAWSON	EMS	884	✓	
Wendy S. McPhee	Self	930		✓ Sec 7-6c
Gill	Self	930		✓ Sec 7-6c
Don Anderson	MT Dept Int'l Hlth	930	✓	
ARLEY WARNER	MT ASSOC OF CHURCHES	HJR 21	✓	
BETH BAKER	MT COUNTY ATTYS ASSN	HB 761	✓	
Mary Callagher	Board of Visitors/ MAP	HB 930	X	
BRUCE DESONIA	Mt. Dept. Health - PHSB	HB 917	✓	
Marty Onishuk	Mont. Alliance for the Handicapped	H 930	✓	
Judy Williams	Self	H 761 H 917		
Stacy Campanelli	Mont. Nurses Association	HB 917	✓	Varveth
Ray Bell-Moore	Lewis + Clark Health	HB 917	✓	
Tom T. Zander	MT Med CSEA	H 917	✓	
Wendy S. McPhee	Int Women Lobby	761	✓	w/Amendments
Dian Sells	Int Women Lobby	917	✓	
PAUL MEYER	Western Region Mental Health	930	✓	
DRISCELL	AMERICAN COUNCIL OF LIFE INSURANCE	917	✓	
Ronell Hansen	MSCA	H 521	✓	

(Please leave prepared statement with Secretary)

MINUTES

MONTANA SENATE 52nd LEGISLATURE - REGULAR SESSION

COMMITTEE ON PUBLIC HEALTH, WELFARE & SAFETY

Call to Order: By Chairman Dorothy Eck, on April 1, 1991, at
3:40 p.m.

ROLL CALL

Members Present:

Dorothy Eck, Chairman (D)
Eve Franklin, Vice Chairman (D)
James Burnett (R)
Thomas Hager (R)
Judy Jacobson (D)
Bob Pipinich (D)
Thomas Towe (D)

Members Excused:

David Rye (R)

Staff Present: Tom Gomez (Legislative Council)
Christine Mangiantini (Committee Secretary)

Please Note: These are summary minutes. Testimony and
discussion are paraphrased and condensed.

Announcements/Discussion: None.

HEARING ON HOUSE BILL 989

Presentation and Opening Statement by Sponsor:

Representative Brent Cromley opened by saying this bill revises laws relating to food establishments. In 1990 the Food and Drug Administration issued a report of a random survey of 75 restaurants in Montana. The average score was 70, as it related to health. Had it been one point lower it would have been rated as unacceptable. The fee is currently \$50.00, he would like to see it raised to \$75.00. He passed the committee copies of Exhibit #1.

Proponents' Testimony:

The first witness was Mitzi Schwab, representing the Food and Consumer Safety Bureau, Department of Health and Environmental Sciences. See Exhibit #2 for a copy of her testimony.

SENATE PUBLIC HEALTH, WELFARE & SAFETY COMMITTEE

April 1, 1991

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Senator Jacobson said they were adding a special revenue account.

Ms. Schwab said the state portion breakdown is 85 percent returned to the counties and 15 percent deposited into the general fund.

Senator Towe moved adoption of reinstating the stricken language on page 5, line 25 and striking the underlined language. This would allow the late fee to be deposited to the general fund.

There being no objections the motion carried.

Recommendation and Vote:

Senator Towe moved concurrence as amended. There being no objections the motion carried.

EXECUTIVE ACTION ON HOUSE BILL 930

Motion:

Senator Towe moved adoption of the amendments denoted in Exhibit #12 and amendment #2 in Exhibit #13.

Discussion:

Senator Franklin said the issue was when a patient attended the commitment hearing it would be determined whether they had the capacity to consent to treatment. If they did not a guardianship hearing would be set to make decisions about the treatment. Taking care of this, coupled with a study resolution is what she thought was appropriate. She said whatever amendment is adopted, we need to include a study resolution with an effective date. She said she was concerned about the ramifications of the system.

The chairman recognized Kelly Moorse, representing the Board of Visitors. She said there is a provision that allows if someone with a mental illness is not taking their medication they can go to court and reinstate the services in the community. She said voluntary admissions needed to be addressed, 50 percent of the admissions to the State Hospital are voluntary.

The chairman recognized Jim Smith, representing a mental health organization. He said he was included in the conference call between the parties. He said Senator Franklin and Representative Whalen had ideas about what should be done with the bill. He suggested not linking the commitment proceeding to the issue of guardianship. These are two distinct issues. It weakens the due process rights of the person with the mental illness. A voluntary versus an involuntary commitment needs to be addressed. Almost 50 percent of the admissions are on a voluntary basis. If they refuse treatment they can be automatically discharged.

SENATE PUBLIC HEALTH, WELFARE & SAFETY COMMITTEE

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Mr. Smith continued by noting Exhibit #12, proposed amendments by Representative Whalen and said he would recommend adoption. He said they think the idea of a study is worthy. He asked that the committee not delay implementation of the proposed amendments and the bill.

Senator Franklin said she wanted a study inserted into the bill.

Senator Pipinich said they faxed proposed amendments to Warm Springs personnel. He said he received a telephone call from one of the parties and they asked for a study resolution.

Amendments, Discussion, and Votes:

There being no objections the motion carried.

Recommendation and Vote:

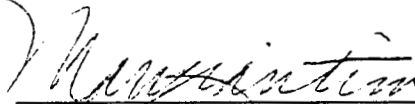
Senator Towe moved concurrence as amended. There being no objections the motion carried.

ADJOURNMENT

Adjournment At: 8:34 p.m.



SENATOR DOROTHY ECK, Chairman



CHRISTINE MANGIANTINI, Secretary

DE/cm

ROLL CALL VOTE

SENATE COMMITTEE PUBLIC HEALTH, WELFARE & SAFETY

Date 04/01/91

H Bill No. 930

Time 8:30 p.m.

NAME	YES	NO
SENATOR BURNETT	X	
SENATOR FRANKLIN	X	
SENATOR HAGER	X	
SENATOR JACOBSON	X	
SENATOR PIPINICH	X	
SENATOR RYE	X	
SENATOR TOWE	X	
SENATOR ECK	X	

Secretary

Chairman

Motion: Senator Towe moved adoption of the amendments denoted in
Exhibit #12 and amendment #2 in Exhibit #13. There being
no objections the motion carried.

ROLL CALL VOTE

SENATE COMMITTEE PUBLIC HEALTH, WELFARE & SAFETY

Date 04/01/91

H Bill No. 930

Time 8:33 p.m.

NAME	YES	NO
SENATOR BURNETT	X	
SENATOR FRANKLIN	X	
SENATOR HAGER	X	
SENATOR JACOBSON	X	
SENATOR PIPINICH	X	
SENATOR RYE	X	
SENATOR TOWE	X	
SENATOR ECK	X	

Secretary

Chairman

Motion: Senator Towe moved concurrence as amended. There being
no objections the motion carried.

SENATE STANDING COMMITTEE REPORT

Page 1 of 1
April 2, 1991

MR. PRESIDENT:

We, your committee on Public Health, Welfare, and Safety having had under consideration House Bill No. 930 (third reading copy -- blue), respectfully report that House Bill No. 930 be amended and as so amended be concurred in:

1. Page 17, line 15.

Following: line 14

Insert: "(7) In the case of a patient who lacks the capacity to exercise the right to consent to treatment described in subsection (6)(c), the right must be exercised on behalf of the patient by a guardian appointed pursuant to the provisions of Title 72, chapter 5.

(8) The department shall develop procedures for initiating limited guardianship proceedings in the case of a patient who appears to lack the capacity to exercise the right to consent described in subsection (6)(c)."

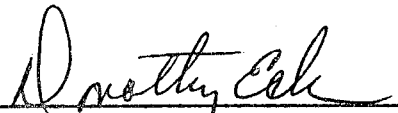
2. Page 19, line 19.

Following: line 18

Insert: "NEW SECTION. Section 10. Report to legislature. The department of institutions shall submit a report to the 53rd legislature concerning implementation of [section 7(6)(c) through (8)]."

Renumber: subsequent section

Signed: _____


Dorothy Eck, Chairman

LB 4/2/91
Amd. Coord.

SB 4/2
Sec. of Senate

SENATE
HB 930

1 HOUSE BILL NO. 930

2 INTRODUCED BY WHALEN, BLAYLOCK, LYNCH, MCCARTHY, MENAHAN,
3 DAILY, HARRINGTON, G. BECK, JACOBSON, COCCHIARELLA,
4 KIMBERLEY, PAVLOVICH, BRADLEY

5
6 A BILL FOR AN ACT ENTITLED: "AN ACT INCORPORATING INTO
7 MONTANA LAW THE FEDERAL PROVISIONS REGARDING PROTECTION AND
8 ADVOCACY FOR THE MENTALLY ILL; OUTLINING THE GOALS AND
9 AUTHORITY OF AN ELIGIBLE PROTECTION AND ADVOCACY SYSTEM FOR
10 THE MENTALLY ILL IN MONTANA; AND AMENDING SECTIONS
11 53-21-141, 53-21-142, 53-21-144, 53-21-146, 53-21-147,
12 53-21-162, 53-21-166, AND 53-21-181, MCA."

13
14 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

15 NEW SECTION. Section 1. Protection and advocacy system

16 -- designation and authority. (1) A protection and advocacy
17 system for individuals with a significant mental illness or
18 emotional impairment is designated by the governor and may
19 be administered in the state under the provisions of 42
20 U.S.C. 10801 through 10851. An eligible mental health
21 protection and advocacy system under the provisions of 42
22 U.S.C. 10801 through 10851 must have as its primary goals:

23 (a) the protection and advocacy of the rights of
24 mentally ill individuals who are defined in 42 U.S.C. 10802
25 as individuals with a significant mental illness or

1 emotional impairment; and

2 (b) the investigation of incidents of abuse and
3 neglect, as defined in 42 U.S.C. 10802, of mentally ill
4 individuals.

5 (2) Pursuant to 42 U.S.C. 10801 through 10802, the
6 protection and advocacy system may:

7 (a) investigate incidents of abuse and neglect of
8 mentally ill individuals;

9 (b) pursue administrative, legal, and other appropriate
10 remedies to ensure the protection of mentally ill
11 individuals who are residents of the state and are receiving
12 care or treatment in the state;

13 (c) have access to all mentally ill individuals and all
14 facilities, wards, and living quarters as necessary to
15 fulfill the goals described in subsection (1); and

16 (d) pursuant to 42 U.S.C. 10801 through 10851 and Title
17 50, chapter 16, part 5, have access to records, including:

18 (i) reports prepared by the staff of a mental health
19 care and treatment facility;

20 (ii) reports prepared by an agency investigating
21 reports of abuse, neglect, and injury occurring at a
22 facility and that describe the incidents and the steps taken
23 to investigate the reports; and

24 (iii) discharge planning records.

25 (3) All information obtained under this section must be

1 kept confidential pursuant to 42 U.S.C. 10806.

2 (4) The protection and advocacy system described in
3 this section is independent of any public or private agency
4 that provides treatment or services to the mentally ill.

5 **Section 2.** Section 53-21-141, MCA, is amended to read:

6 "53-21-141. Civil and legal rights of person committed.

7 (1) Unless specifically stated in an order by the court, a
8 person involuntarily committed to a facility for a period of
9 evaluation or treatment does not forfeit any legal right or
10 suffer any legal disability by reason of the provisions of
11 this part except insofar as it may be necessary to detain
12 the person for treatment, evaluation, or care. All
13 communication between an alleged mentally ill person and a
14 professional person is privileged under normal privileged
15 communication rules unless it is clearly explained to the
16 person in advance that the purpose of an interview is for
17 evaluation and not treatment.

18 (2) Whenever a person is committed to a mental health
19 facility for a period of 3 months or longer, the court
20 ordering the commitment may make an order stating
21 specifically any legal rights which are denied the
22 respondent and any legal disabilities which are imposed on
23 him. As part of its order, the court may appoint a person to
24 act as conservator of the respondent's property. Any
25 conservatorship created pursuant to this section terminates

1 upon the conclusion of the involuntary commitment if not
2 sooner terminated by the court. A conservatorship or
3 guardianship extending beyond the period of involuntary
4 commitment may not be created except according to the
5 procedures set forth under Montana law for the appointment
6 of conservators and guardians generally. In the case of a
7 person admitted to a program or facility for the purpose of
8 receiving mental health services, an individual employed by
9 or receiving remuneration from the program or facility may
10 not act as the person's guardian or representative unless
11 the program or facility can demonstrate that no other person
12 is available or willing to act as the person's guardian or
13 representative.

14 (3) A person who has been committed to a mental health
15 facility pursuant to this part is automatically restored
16 upon the termination of the commitment to all of his civil
17 and legal rights which may have been lost when he was
18 committed. This subsection does not affect, however, a
19 guardianship or conservatorship created independently of the
20 commitment proceedings according to the provisions of
21 Montana law relating to the appointment of conservators and
22 guardians generally. A person who leaves a mental health
23 facility following a period of evaluation and treatment
24 shall be given a written statement setting forth the
25 substance of this subsection.

1 (4) A person committed to a mental health facility
2 prior to July 1, 1975, enjoys all the rights and privileges
3 of a person committed after that date."

4 **Section 3.** Section 53-21-142, MCA, is amended to read:

5 "53-21-142. Rights of persons admitted to facility.
6 Patients admitted to a mental health facility, whether
7 voluntarily or involuntarily, shall have the following
8 rights:

9 (1) Patients have a right to privacy and dignity.

10 (2) Patients have a right to the least restrictive
11 conditions necessary to achieve the purposes of commitment.
12 Patients must be accorded the right to appropriate treatment
13 and related services in a setting and under conditions that:

14 (a) are the most supportive of the patient's personal
15 liberty; and

16 (b) restrict the patient's liberty only to the extent
17 necessary and consistent with the patient's treatment need,
18 applicable requirements of law, and judicial orders.

19 (3) Patients shall have the same rights to visitation
20 and reasonable access to ~~private~~ telephone communications,
21 including the right to converse with others privately, as
22 patients-at-any-public-hospitals except to the extent that
23 the professional person responsible for formulation of a
24 particular patient's treatment plan writes an order imposing
25 special restrictions. The written order must be renewed

1 after each periodic review of the treatment plan if any
2 restrictions are to be continued. Patients shall have an
3 unrestricted right to visitation with attorneys, with
4 spiritual counselors, and with private physicians and other
5 professional persons.

6 (4) Patients shall have an unrestricted right to send
7 sealed mail. Patients shall have an unrestricted right to
8 receive sealed mail from their attorneys, private physicians
9 and other professional persons, the mental disabilities
10 board of visitors, courts, and government officials.
11 Patients shall have a right to receive sealed mail from
12 others except to the extent that a professional person
13 responsible for formulation of a particular patient's
14 treatment plan writes an order imposing special restrictions
15 on receipt of sealed mail. The written order must be renewed
16 after each periodic review of the treatment plan if any
17 restrictions are to be continued.

18 (5) Patients have an unrestricted right to have access
19 to letter-writing materials, including postage, and have a
20 right to have staff members of the facility assist persons
21 who are unable to write, prepare, and mail correspondence.

22 (6) Patients have a right to wear their own clothes and
23 to keep and use their own personal possessions, including
24 toilet articles, except insofar as such clothes or personal
25 possessions may be determined by a professional person in

charge of the patient's treatment plan to be dangerous or otherwise inappropriate to the treatment regimen. The facility has an obligation to supply an adequate allowance of clothing to any patients who do not have suitable clothing of their own. Patients shall have the opportunity to select from various types of neat, clean, and seasonable clothing. Such clothing shall be considered the patient's throughout his stay at the facility. The facility shall make provision for the laundering of patient clothing.

(7) Patients have the right to keep and be allowed to spend a reasonable sum of their own money.

(8) Patients have the right to religious worship. Provisions for such worship shall be made available to all patients on a nondiscriminatory basis. No individual shall be required to engage in any religious activities.

(9) Patients have a right to regular physical exercise several times a week. Moreover, it shall be the duty of the facility to provide facilities and equipment for such exercise. Patients have a right to be outdoors at regular and frequent intervals in the absence of contrary medical considerations.

(10) Patients have the right to be provided, with adequate supervision, suitable opportunities for interaction with members of the opposite sex except to the extent that a professional person in charge of the patient's treatment

plan writes an order stating that such interaction is inappropriate to the treatment regimen.

(11) Patients have a right to receive prompt and adequate medical treatment for any physical ailments. In providing medical care, the mental health facility shall take advantage of whatever community-based facilities are appropriate and available and shall coordinate the patient's treatment for mental illness with his medical treatment.

(12) Patients have a right to a diet that will provide at a minimum the recommended daily dietary allowances as developed by the national academy of sciences. Provisions shall be made for special therapeutic diets and for substitutes at the request of the patient or the friend of respondent in accordance with the religious requirements of any patient's faith. Denial of a nutritionally adequate diet shall not be used as punishment.

(13) Patients have a right to a humane psychological and physical environment within the mental health facilities. These facilities shall be designed to afford patients with comfort and safety, promote dignity, and ensure privacy. The facilities shall be designed to make a positive contribution to the efficient attainment of the treatment goals set for the patient. In order to assure the accomplishment of this goal:

(a) regular housekeeping and maintenance procedures

which will ensure that the facility is maintained in a safe, clean, and attractive condition shall be developed and implemented;

(b) there must be special provision made for geriatric and other nonambulatory patients to assure their safety and comfort, including special fittings on toilets and wheelchairs. Appropriate provision shall be made to permit nonambulatory patients to communicate their needs to the facility staff.

(c) pursuant to an established routine maintenance and repair program, the physical plant of every facility shall be kept in a continuous state of good repair and operation in accordance with the needs of the health, comfort, safety, and well-being of the patients;

(d) every facility must meet all fire and safety standards established by the state and locality. In addition, any hospital shall meet such provisions of the life safety code of the national fire protection association as are applicable to hospitals. Any hospital shall meet all standards established by the state for general hospitals insofar as they are relevant to psychiatric facilities.

(14) A patient at a facility has the right:

(a) to be informed of the rights described in this section at the time of his admission and periodically thereafter, in language and terms appropriate to the

patient's condition and ability to understand;

(b) to assert grievances with respect to infringement of the rights described in this section, including the right to have a grievance considered in a fair and timely manner according to an impartial grievance procedure that must be provided for by the facility; and

(c) to exercise the rights described in this section without reprisal and may not be denied admission to the facility as reprisal for the exercise of the rights described in this section.

(15) In order to assist a person admitted to a program or facility in the exercise or protection of the patient's rights, the patient's attorney, advocate, or legal representatives shall have reasonable access to:

(a) the patient;

(b) the program or facility areas where the patient has received treatment or has resided or the areas to which he has had access; and

(c) pursuant to the written authorization of the patient, records and information pertaining to the patient's diagnosis, treatment, and related services.

(16) A person admitted to a facility shall have access to any available individual or service that provides advocacy for the protection of the person's rights and that assist the person in understanding, exercising and

protecting his rights as described in this section.

(17) This section may not:

(a) obligate a professional person to administer treatment contrary to the professional's clinical judgment;

(b) prevent a facility from discharging a patient for whom appropriate treatment, consistent with the clinical judgment of a professional person responsible for the patient's treatment, is or has become impossible to administer because of the patient's refusal to consent to the treatment;

(c) require a facility to admit a person who has, on prior occasions, repeatedly withheld consent to appropriate treatment; or

(d) obligate a facility to treat a person admitted to the facility solely for diagnostic evaluation."

Section 4. Section 53-21-144, MCA, is amended to read:

"53-21-144. Rights concerning photographs. (1) A person admitted to a mental health facility may be photographed upon admission for identification and the administrative purposes of the facility. Such photographs shall be confidential and shall not be released by the facility except pursuant to court order.

(2) No other nonmedical photographs shall be taken or used without consent of the patient or, if applicable, the patient's legal guardian or--the--friend--of---respondent

appointed-by-the-court."

Section 5. Section 53-21-146, MCA, is amended to read:

"53-21-146. Right to be free from physical restraint and isolation. Patients have a right to be free from physical restraint and isolation. Except for emergency situations in which it is likely that patients could harm themselves or others and in which less restrictive means of restraint are not feasible, patients may be physically restrained or placed in isolation only on a professional person's written order which explains the rationale for such action. The written order may be entered only after the professional person has personally seen the patient concerned and evaluated whatever episode or situation is said to call for restraint or isolation. Emergency use of restraints or isolation shall be for no more than 1 hour, by which time a professional person shall have been consulted and shall have entered an appropriate order in writing. Such written order shall be effective for no more than 24 hours and must be renewed if restraint and isolation are to be continued. Whenever a patient is subject to restraint or isolation, adequate care shall be taken to monitor his physical and psychiatric condition and to provide for his physical needs and comfort. Physical restraint may not be used as punishment, for the convenience of the staff, or as a substitute for a treatment program."

Section 6. Section 53-21-147, MCA, is amended to read:

"53-21-147. Right not to be subjected to experimental research. (1) Patients shall have a right not to be subjected to experimental research without the express and informed consent of the patient, if the patient is able to give such consent, and of his guardian, if any, and the friend of respondent appointed by the court after opportunities for consultation with independent specialists and with legal counsel. If there is no friend of respondent or if the friend of respondent appointed by the court is no longer available, then a friend of respondent who is in no way connected with the facility, the department, or the research project shall be appointed prior to the involvement of the patient in any experimental research. At least 10 days prior to the commencement of such experimental research, the facility shall send notice of intent to involve the patient in experimental research to the patient, his next of kin, if known, his legal guardian, if any, the attorney who most recently represented him, and the friend of respondent appointed by the court.

(2) Such proposed research shall first have been reviewed and approved by the mental disabilities board of visitors before such consent shall be sought. Prior to such approval, the board shall determine that such research complies with the principles of the statement on the use of

human subjects for research of the American association on mental deficiency and with the principles for research involving human subjects required by the United States department of health, education, and welfare for projects supported by that agency.

(3) A patient has the right to appropriate protection before participating in an experimental treatment, including the right to a reasonable explanation of the procedure to be followed, expected benefits, relative advantages, and the potential risks and discomforts of any experimental treatment. A patient has the right to revoke at any time consent to an experimental treatment."

Section 7. Section 53-21-162, MCA, is amended to read:

"53-21-162. Establishment of patient treatment plan -- patient's rights. (1) Each patient admitted as an inpatient to a mental health facility shall have a comprehensive physical and mental examination and review of behavioral status within 48 hours after admission to the mental health facility.

(2) Each patient shall have an individualized treatment plan. This plan shall be developed by appropriate professional persons, including a psychiatrist, and shall be implemented no later than 10 days after the patient's admission. Each individualized treatment plan shall contain:

(a) a statement of the nature of the specific problems

1 and specific needs of the patient;

2 (b) a statement of the least restrictive treatment
3 conditions necessary to achieve the purposes of commitment;

4 (c) a description of intermediate and long-range
5 treatment goals, with a projected timetable for their
6 attainment;

7 (d) a statement and rationale for the plan of treatment
8 for achieving these intermediate and long-range goals;

9 (e) a specification of staff responsibility and a
10 description of proposed staff involvement with the patient
11 in order to attain these treatment goals;

12 (f) criteria for release to less restrictive treatment
13 conditions and criteria for discharge; and

14 (g) a notation of any therapeutic tasks and labor to be
15 performed by the patient.

16 (3) As part of his treatment plan, each patient shall
17 have an individualized after-care plan. This plan shall be
18 developed by a professional person as soon as practicable
19 after the patient's admission to the facility.

20 (4) In the interests of continuity of care, whenever
21 possible one professional person (who need not have been
22 involved with the development of the treatment plan) shall
23 be responsible for supervising the implementation of the
24 treatment plan, integrating the various aspects of the
25 treatment program, and recording the patient's progress.

1 This professional person shall also be responsible for
2 ensuring that the patient is released, where appropriate,
3 into a less restrictive form of treatment.

4 (5) The treatment plan shall be continuously reviewed
5 by the professional person responsible for supervising the
6 implementation of the plan and shall be modified if
7 necessary. Moreover, at least every 90 days each patient
8 shall receive a mental examination from and his treatment
9 plan shall be reviewed by a professional person other than
10 the professional person responsible for supervising the
11 implementation of the plan.

12 (6) A patient has the right:

13 (a) to ongoing participation, in a manner appropriate
14 to the patient's capabilities, in the planning of mental
15 health services to be provided and in the revision of the
16 plan;

17 (b) to a reasonable explanation of the following, in
18 terms and language appropriate to the patient's condition
19 and ability to understand:

20 (i) the patient's general mental condition and, if
21 given a physical examination, the patient's physical
22 condition;

23 (ii) the objectives of treatment;

24 (iii) the nature and significant possible adverse
25 effects of recommended treatments;

(iv) the reasons why a particular treatment is considered appropriate;

(v) the reasons why access to certain visitors may not be appropriate; and

(vi) any appropriate and available alternative treatments, services, or providers of mental health services; and

(c) not to receive treatment established pursuant to the treatment plan in the absence of the patient's informed, voluntary, and written consent to the treatment, except treatment;

(i) during an emergency situation if the treatment is pursuant to or documented contemporaneously by the written order of a responsible mental health professional; or

(ii) permitted under the applicable law in the case of a person committed to a facility by a court.

(7) IN THE CASE OF A PATIENT WHO LACKS THE CAPACITY TO EXERCISE THE RIGHT TO CONSENT TO TREATMENT DESCRIBED IN SUBSECTION (6)(C), THE RIGHT MUST BE EXERCISED ON BEHALF OF THE PATIENT BY A GUARDIAN APPOINTED PURSUANT TO THE PROVISIONS OF TITLE 72, CHAPTER 5.

(8) THE DEPARTMENT SHALL DEVELOP PROCEDURES FOR INITIATING LIMITED GUARDIANSHIP PROCEEDINGS IN THE CASE OF A PATIENT WHO APPEARS TO LACK THE CAPACITY TO EXERCISE THE RIGHT TO CONSENT DESCRIBED IN SUBSECTION (6)(C)."

Section 8. Section 53-21-166, MCA, is amended to read:

"53-21-166. Records to be confidential -- exceptions.

All information obtained and records prepared in the course of providing any services under this part to individuals under any provision of this part shall be confidential and privileged matter and shall remain confidential and privileged after the individual is discharged from the facility. Except as provided in Title 50, chapter 16, part 5, information and records may be disclosed only:

(1) in communications between qualified professionals in the provision of services or appropriate referrals;

(2) when the recipient of services designates persons to whom information or records may be released, provided that if a recipient of services is a ward and his guardian or conservator designates in writing persons to whom records or information may be disclosed, such designation shall be valid in lieu of the designation by the recipient; except that nothing in this section shall be construed to compel a physician, psychologist, social worker, nurse, attorney, or other professional person to reveal information which has been given to him in confidence by members of a patient's family;

(3) to the extent necessary to make claims on behalf of a recipient of aid, insurance, or medical assistance to which he may be entitled;

(4) for research if the department has promulgated rules for the conduct of research; such rules shall include but not be limited to the requirement that all researchers must sign an oath of confidentiality;

(5) to the courts as necessary to the administration of justice;

(6) to persons authorized by an order of court, after notice and opportunity for hearing to the person to whom the record or information pertains and the custodian of the record or information pursuant to the rules of civil procedure;

(7) to members of the mental disabilities board of visitors or their agents when necessary to perform their functions as set out in 53-21-104."

Section 9. Section 53-21-181, MCA, is amended to read:

"53-21-181. Discharge during or at end of initial commitment period -- patient's right to referral. (1) At any time within the 3-month period provided for in 53-21-127(2), the patient may be discharged on the written order of the professional person in charge of him. In the event the patient is not discharged within the 3-month period and if the term is not extended as provided for in 53-21-128, he shall be discharged by the facility at the end of 3 months without further order of the court. Notice of the discharge shall be filed with the court and the county

attorney at least 5 days prior to the discharge.

(2) Upon being discharged, each patient has a right to be referred, as appropriate, to other providers of mental health services."

NEW SECTION. SECTION 10. REPORT TO LEGISLATURE. THE DEPARTMENT OF INSTITUTIONS SHALL SUBMIT A REPORT TO THE 53RD LEGISLATURE CONCERNING IMPLEMENTATION OF [SECTION 7(6)(C) THROUGH (8)].

NEW SECTION. Section 11. Codification instruction. [Section 1] is intended to be codified as an integral part of Title 53, chapter 21, and the provisions of Title 53, chapter 21, apply to [section 1].

-End-